

GMH EMPLOYEES ASSOCIATION MEMBERSHIP APPLICATION

APPLICATION INFORMATION

Name:		
Date of Birth:	SSN #:	Telephone No.:
Department:	How Long?	

EMPLOYMENT INFORMATION

Current Employer:	Guam Memorial Hospital Authority	
Employer Address:	850 Gov. Carlos G. Camacho Road, Tamuning, Guam 96931	
Telephone No.:	(671) 647-2555 or 2330	
Position Title:	Email:	Fax No.:

EMERGENCY CONTACT INFORMATION

Name of a relative not residing with you:	
Address:	Contact No.:

SPOUSE INFORMATION IF JOINT MEMBERSHIP

Name:		
Date of Birth:	SSN #:	Telephone No.:

SPOUSE EMPLOYMENT INFORMATION

Employer Name:
Employer Address:
Telephone No.:

REFERENCES

Name:	Telephone No.:
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SIGNATURES

GMHEA OFFICER

I authorize the verification of the information provided on this as to my employment. I authorize the Payroll Section to withhold from my bi-weekly wages the amount of \$3.00, (\$5.00 if joint), effective the following pay period after the date shown in this application. Make such deductions payable to GMHEA, unless otherwise advised. I have received a copy of this application.

Signature of Applicant:	Date:
Signature of Spouse: (Only if for JOINT MEMBERSHIP)	Date:
Signature of GMHEA OFFICER:	Date: